

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-069463

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1548

STATE FILE NUMBER

FILED FEB 19 1963 SL-13756 XC-1 228 062

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b 5 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.		d. STREET ADDRESS (If outside, give location) 1636 CORNELIUS AVE.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last STRECKER		4. DATE OF DEATH Month 2 Day 11 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Huttig Co.	
11. BIRTHPLACE (City and state or country) ELLISVILLE, MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME RIENHART STRECKER		13b. MOTHER'S MAIDEN NAME LOUISE Wolff	
14. NAME OF HUSBAND OR WIFE Mabel Miller Strecker		Address 6395 CONNECTICUT ST. LOUIS, MO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II		16. SOCIAL SECURITY NO. 4200	
17. INFORMANT LAWRENCE STRECKER (SON)		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA CONGESTIVE HEART FAILURE ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 4:30 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION ST. LOUIS, MO.
21. I attended the deceased from 2/6/63 to 2/11/63 and last saw him alive on 2/11/63 Death occurred at 4:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 2/12/63	
22a. SIGNATURE Edward C. Miller M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/14/63	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR E. J. Schnur		25. DATE RECD. BY LOCAL REG. FEB 13 1963	
26. ADDRESS 3125 Lafayette Ave.		27. REGISTRAR'S SIGNATURE Paul Smith, M.D.	

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joe B. Vollmer

Licensed Embalmer No. 404

P. O. Address 325 Lafayette St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.